

INFECTIOUS DISEASE SCREENING MEASURES IN CRS

Prenatal HIV (GPRA)

HIV Screening 13-64 y.o. Ever (Dev GPRA)

Chlamydia Screening, annual, 16-24 y.o. (Dev GPRA)

HCV Screening boomers (born 1945-1965) (Dev GPRA)

WHEN DO WE SCREEN

- Condition is largely asymptomatic
 - Test is reliable, inexpensive, and noninvasive
 - Improved outcome for patient when detected early
 - Risk factors not evident or disclosed
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PRENATAL HIV SCREENING-RATIONALE

-1996 screen all blood donors

-2001 screen all pregnant women



PRENATAL HIV SCREENING-RESULTS

2005: 61%

2014: 90%

Excellent result, well ahead of 2020 goals

We will likely not be able to further increase screening rates nationwide



HIV 13-64 Y.O. SCREENING-RATIONALE

- 1996 blood donors
- 2001 all prenatal patients
- 2008 all persons 13-64



HIV SCREENING-RATIONALE

- rare but important to detect
- critical for patient survival
- patients have no apparent symptoms or risk factors
- AI/AN have quickest progression of AIDS to death, which may be a result of late diagnosis



HIV SCREENING-RESULTS

-2012 31%

-2014 41%

Relative increase of 31% in unique patients tested in last two years

Strong results, but many sites lagging <25%



CHLAMYDIA SCREENING-RATIONALE

- widespread disease
 - patient mostly asymptomatic
 - long term health damage including pelvic inflammatory disease, infertility, and other adverse health effects
 - only women in national recommendation
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CHLAMYDIA SCREENING-RESULTS

2014: 36%, nearly identical with 2013

Not improving as quickly as other measures

PAP screen recommendation changes

How to better include in emergency medicine settings

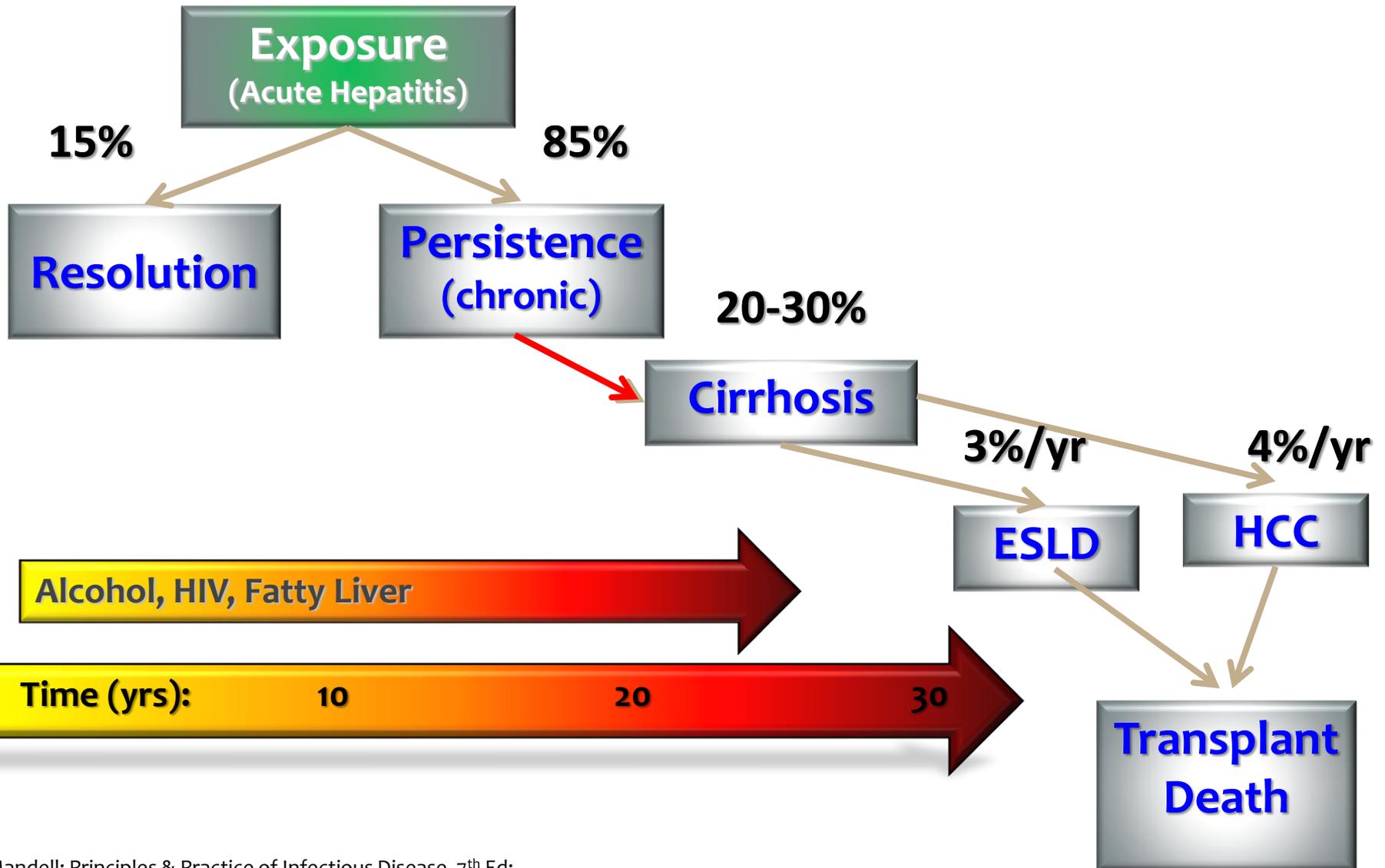
Site audits found many systematic missed opportunities



HCV SCREENING-RATIONALE

- Persons born 1945-1965 constitute 75% of HCV patients
 - a majority of patients do not know they are infected
 - recent drug breakthroughs mean a very high cure rate (over 90%) in 12 weeks, with no major side effects
 - IHS already has over 25,000 patients with an HCV POV
 - Transmission is primarily bloodborne, no HCV test prior to 1992
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NATURAL HISTORY OF HEPATITIS C



PROGRESSION OF DISEASE

Disease progression is variable and non-linear

Modifiable factors are important in disease progression and should be addressed

- Weight loss
- Diabetes control
- Alcohol and marijuana



DIABETES

Risk increased by 70% compared to non-infected controls (OR 1.7)

Linked to insulin resistance without overt diabetes

Successful HCV treatment associated with decrease in insulin resistance and reduction in incidence of diabetes mellitus

ACTION 1 CATCH UP ON HCV+ BACKLOG

Audit of IHS site charts of HCV+ patients

- Most sites have many HCV+ patients who now need follow up
 - Need to identify and contact patients for pre-treatment checklist
 - Need to triage most urgent patients
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ACTION 2: START HCV SCREENING

EHR reminder exists

Sample standing protocol

Some IHS sites above 50% already

Linkage to care should be centralized



ACTION 3: TREATMENT

New regimens make treatment of uncomplicated patients possible at primary care level

May need to eventually plan HCV clinic with clinical lead

Telehealth options exist specifically for IHS



ACTION 3B HOW DO WE PAY FOR IT

Drugs are over \$1000 per pill. We can't afford it, so we don't pay for it:

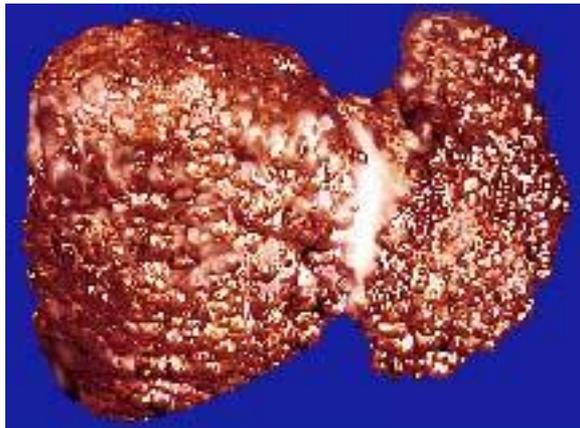
Patient Assistance Programs

- Generally require stage 3 or higher to qualify
- Cost containment, not clinical criteria
- Patients not being denied twice so far

WHAT DO WE GET WITH HCV TREATMENT?

SVR (cure) of HCV is associated with:

- **70%** Reduction of Liver Cancer
- **50%** Reduction in All-cause Mortality
- **90%** Reduction in Liver Failure



BARRIERS TO SCREENING

Time constraints/too busy

Forget

Competing priorities, can't target everything

Everyone should do it, then nobody does



BEST PRACTICES

Make screen automatic/systematic via at least one of the following:

- Standing orders/protocols

- Reminders in EHR

- Clear delegation for screening, away from provider

- Knowing own screening data (federal vs. tribal sites)

